Incident To in Provider-Based Departments

WHITE PAPER

by Kimberly Anderwood Hoy, JD, CPC, Director of Medicare and Compliance, HCPro, Inc.

FEATURES

Meet Medicare's ordering, supervision, and follow-up requirements

Background

Less than 10 words in the Social Security Act create a world of confusion—not to mention massive headaches—for countless providers who offer outpatient services potentially covered under the Medicare program.

The words are found in the Social Security Act § 1861(s)(2)(B), which states that Medicare covers services "incident to physicians' services rendered to outpatients." For hospital outpatient services to be covered, they must meet the requirements under this "incident to" provision, unless the provider can find another basis of coverage, such as the specific coverage of physical and occupational therapy, certain diagnostic services, or other services specifically covered under the Social Security Act.

What incident to means for healthcare entities depends largely on whether they are provider-based entities or departments (e.g., provider-based clinics). Provider-based entities must meet the incident-to requirements to qualify for coverage. If a patient's hospital outpatient encounter doesn't meet CMS' incident-to criteria for hospital outpatient services, the hospital may not bill for the claim.

The term incident to applies differently to services provided by physicians' practices and freestanding clinics. If a patient encounter in a physician office doesn't meet incident-to criteria for physician services, there may be other billing options. For example, if a patient is treated by a nonphysician practitioner (NPP) at a time when there is no supervising physician in the office suite, the service may still be billable as a service of the NPP, albeit at a discounted rate (i.e., 85%).

Even though CMS uses the phrase incident to in both settings, the term has a different meaning in each setting. CMS also provides different regulatory provisions covering those settings: 42 *CFR* § 410.26 outlines incident-to requirements for services billed by a physician practice, whereas 42 *CFR* § 410.27 covers requirements for hospitals.

According to 42 *CFR* § 410.27, for a provider-based encounter to qualify for incident-to coverage, the encounter must be furnished:

- By a hospital in the hospital or a provider-based department or clinic as defined in 42 *CFR* § 413.65
- As "an integral although incidental" part of a physician's services in the course of diagnosing or treating the patient
- Under direct physician supervision

The *Medicare Benefit Policy Manual,* Chapter 6 § 20.5.1 reiterates these requirements and provides an additional requirement:

- It must be furnished on the order of a physician or other NPP working within his or her scope of practice

For the purposes of this white paper, we will focus on hospital outpatient incident-to requirements, although we will note the differences between professional and provider requirements when relevant.

Provider-based setting

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Services must be furnished by a hospital in a hospital or a provider-based department or clinic to meet Medicare's hospital outpatient incident-to coverage requirements, according to 42 *CFR* §§ 410.27(a)(1)(i),(iii) and the *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.1.

Medicare has established criteria to determine whether a department is provider-based in 42 *CFR* § 413.65. CMS has provided for a voluntary attestation and determination process. Attesting that a department is provider-based is voluntary, unless the department is off campus and renders physician services of a type ordinarily furnished in a physician office.

In the latter case, a determination through the attestation process is required or CMS will consider the location to be freestanding. If a hospital decides to do an attestation for a department, CMS will make a determination regarding the department's provider-based status. For more on attestation and documentation requirements necessary to qualify for provider-based status, see 42 *CFR* 413.65 and CMS' *Program Memorandum* A-03-030.

There are certain benefits to being provider-based. For example, because Medicare will treat a provider-based clinic or department as it does a hospital outpatient department, reimbursement for covered services is generally greater than for the same service in a freestanding clinic or physician office.

Physician order

Services must be furnished on the order of a physician or other NPP working within his or her scope of practice to be covered under incident to, according to the *Medicare Benefit Policy Manual,* Chapter 6 § 20.5.1. Presumably, services furnished in conjunction with a clinic visit during which the patient actually saw a physician would be considered to have been furnished on a physician's order.

Prior to 2008, this section of the manual did not include language allowing for orders by NPPs. The section was modified in February 2008 (effective January 1, 2008) to include NPPs; however, this change was subsequently removed in a later June 2008 revision (effective July 1, 2008). The removal may have been inadvertent because the provision to allow NPP orders was again included in a January 2009 revision to this section (effective January 1, 2009) and appears in the currently effective version of this manual section.

Physician involvement and follow-up

There must be ongoing involvement on the part of the physician to meet this incident-to coverage requirement. A physician may not simply refer a patient to the hospital for outpatient services without continuing to be involved in managing the course of treatment. This does not mean Medicare requires a physician to see a patient during each hospital outpatient encounter.

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Although a physician does not necessarily need to see a patient during every visit, a patient's physician must personally see him or her periodically and sufficiently often to assess the course of treatment and progress and, where necessary, to change the treatment regimen, according to the *Medicare Benefit Policy Manual,* Chapter 6 § 20.5.1. The *CFR* describes this involvement as "integral although incidental" throughout the course of treatment.

For example, when the Office of Inspector General audited hospital cardiac rehabilitation programs several years ago, it found that a physician simply referring the patient to the program and seeing him or her at the conclusion of the program 12 weeks later did not generally meet this requirement. To demonstrate the physician's ongoing involvement in the course of treatment, even a stable cardiac rehabilitation patient would need to see a physician more than once every three months to meet incident-to requirements.

Another circumstance in which this requirement can be troublesome for hospitals is with patients with chronic conditions. For example, a wound care clinic patient with a slowly healing wound due to diabetes may not be referred back to his or her physician frequently because the wound is healing as expected and he or she may not have other acute conditions. However, to demonstrate the required ongoing involvement of the physician, the patient would have to see the physician "periodically and sufficiently often" for him or her to assess the course of treatment.

However, CMS has not clarified what time frame meets the "sufficiently often" requirement. Based on the cardiac rehabilitation audits, CMS presumably requires a visit with the physician more often than once every three months. At least one visit by the physician would be required, but how often the follow-up should occur is unclear.

Another question that often arises regarding this requirement is whether it is met when a patient leaves an emergency department without seeing

a physician. The answer appears clear based on the guidelines; Medicare requires a physician's visit and order for the services to be an integral though incidental part of a physician's service. Therefore, even when the patient leaves against medical advice, Medicare does not cover any nurse triage services the hospital may have provided because they do not meet the incident-to requirements. In these cases, a hospital may hold the patient responsible for paying for these noncovered services. An advance beneficiary notice is not necessary because it is not an issue of medical necessity. Note that diagnostic and certain other services covered under another basis of coverage may still be covered if the hospital meets the requirements for coverage for those services.

Physician supervision

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During the past year, CMS has clarified that direct physician supervision is required for on- and off-campus hospital provider-based department services to meet Medicare incident-to requirements. The requirement is most clearly stated in 42 *CFR* 410.27(f):

> *Direct supervision means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean the physician must be present in the room when the procedure is performed.*

Although the requirement does not distinguish between on- and off-campus departments, CMS had stated in the April 2000 OPPS implementing regulations that this requirement applies to off-campus departments. CMS further clarified that "direct supervision" requirements for on-campus departments were contained in the *Intermediary Manual* and were "generally assumed" to be met when an encounter occurs on the hospital premises.

In the 2009 proposed and final OPPS rules, CMS clarified that it is its expectation that direct supervision be met in on-campus departments. CMS went on to say that it was concerned that some providers interpreted its statement that it was generally assumed to mean no supervision was required. The final rule states the following:

> *While we have emphasized and will continue to emphasize the direct supervision requirement for off-campus provider-based departments, we do expect direct physician supervision of all hospital outpatient therapeutic services, regardless of their on-campus or off-campus location.*

CMS also clarified important portions of the definition for direct supervision, which may change providers' understanding of the operations of their provider-based departments.

The regulatory definition requires that the physician be on the premises. CMS defines "on the premises" as present on the premises of the entity

afforded provider-based status, meaning a physician must be present in a provider-based department to meet the supervision requirement, according to the *Federal Register* (Vol. 73, p. 68704).

Thus, having a physician "in the hospital," "in the building," or "in the area" is insufficient; the supervising physician must be "in the department." But because providers do not have to make attestations for determination of provider-based status, many providers have departments or entities that have, appropriately, not been "afforded" provider-based status. This left providers wondering how CMS would define a department in certain scenarios, and they brought their questions to Hospital Open Door Forums held in January and February.

In those sessions, CMS deferred to the definition of a department in the provider-based regulations located at 42 *CFR* § 413.65. When pressed, CMS said it would be up to hospitals to determine what a department is within their hospital and referred to an "organized activity." But CMS also indicated some limitation if the hospital defined "department" so broadly that the physician would not be immediately available to intervene as required by the regulation. As an example, CMS stated that when a hospital considers inpatient and outpatient cardiology departments to be two separate departments, CMS would also. However, when the hospital considers them to be the same department, CMS would as well, provided that a supervising physician in the department was immediately available.

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Another clarification related to the definition of "physician" for purposes of the physician who must be present to provide the supervision. CMS explained in the 2009 OPPS final rule that a physician within the meaning of the regulation must be an MD, DO, dentist, optometrist, podiatrist, or chiropractor. CMS has clarified that nurse practitioners (NP) or physician assistants (PA) may not provide the physician supervision in provider-based departments in the *Federal Register*, Vol. 73, p. 68704.

These extension providers often provide care in hospital-based clinics (e.g., urgent care centers or fast-track facilities) without a physician being present in the department; in fact, they sometimes cover when the physician is unable to be present. However, the facility portion of this service is a hospital service subject to the direct supervision requirements of the incident-to regulations. Therefore, in accordance with the direct supervision guidelines discussed in the 2009 OPPS final rule, a physician must be present in the department for Medicare to cover the hospital facility service.

Some confusion has arisen because these visits are generally appropriate under most state laws that allow NPs and PAs to practice without a physician on the premises. Additionally, the professional service by a NP or PA need not be under direct supervision for the service to be billable as a covered professional service to Medicare. The NP or PA would simply bill under

his or her NPI and be paid at a lower rate. Because the service is provided within the NP's and PA's scope of practice and is generally thought of as a professional service, many providers have not considered that the hospital direct supervision requirements apply to the facility portion—and that without a physician present, the hospital facility service is not covered.

In addition, the supervision requirements for diagnostic testing differ from therapeutic services. The Medicare Physician Fee Schedule and local contractors instead determine appropriate supervision requirements for diagnostic services. This remains unchanged in the 2009 OPPS final rule, which states the following:

> *We have not subsequently issued new requirements for the physician supervision of diagnostic tests in provider-based departments of hospitals. Instead, we have continued to follow the supervision requirements for individual diagnostic tests as listed in the Physician Fee Schedule Relative Value File.*

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Finally, note that there may be particular services for which CMS or a local Medicare administrative contractor requires a different level of supervision than required under the incident-to regulations. They may require heightened levels of supervision beyond the incident-to requirements discussed above, regardless of whether they occur on or off the hospital's premises. Additionally, at least three categories of service appear to require a lower level of supervision. Congress amended the Social Security Act to add benefit categories for cardiac rehabilitation, pulmonary rehabilitation, and intensive cardiac rehabilitation, which state that physician supervision will be "presumed" when they are provided "in a hospital."

Resources

Providers should consider reading *CFR* 42 § 410.27 (on the Web at *http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr410.27.pdf)* and the *Medicare Benefit Policy Manual,* Chapter 6 § 20.4–5 *(www.cms.hhs.gov/manuals/downloads/bp102c06.pdf),* which provide interpretive guidance for incident-to coverage requirements. Both are quite short and worth reading. Note that CMS clarified some of the language in this section of the policy manual in *Transmittal 82,* dated February 8, 2008, and *Transmittal 90,* dated June 19, 2008. View these transmittals at *www.cms.hhs.gov/transmittals/downloads/R82BP.pdf* and *www.cms.hhs.gov/Transmittals/downloads/R90BP.pdf,* respectively.

Those interested in professional incident-to requirements may review the *Medicare Benefit Policy Manual,* Chapter 15 §§ 60.1–60.3 *(www.cms.hhs.gov/manuals/downloads/bp102c15.pdf)* in addition to *CFR* 42 § 410.26 *(http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr410.26.pdf).*

Some types of hospital outpatient services (e.g., physical and occupational therapy, speech-language pathology services, and hospital outpatient diagnostic services) are covered independently of the incident-to requirements.

For more information on physical and occupational therapy and speech pathology coverage, see the *Medicare Benefit Policy Manual,* Chapter 15 §§ 220 and 230 *(www.cms.hhs.gov/manuals/downloads/bp102c15.pdf).*

Finally, the Social Security Act § 1861(s)(2)(B) is available on the Web at *www.ssa.gov/OP_Home/ssact/title18/1861.htm*. ■

Editor's note: Hoy is the director of Medicare and compliance at HCPro, Inc., and the lead instructor for HCPro's Medicare Boot Camp®–Hospital Version. She is also a lead consultant for HCPro's Revenue Cycle Institute (www.revenuecycleinstitute.com).